NEW JERSEY STATE DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF LIFE AND HEALTH
MANAGED CARE BUREAU
POST OFFICE 325
TRENTON, NEW JERSEY 08625

WORKERS' COMPENSATION MANAGED CARE ORGANIZATION APPLICATION (WCMCO)

Instructions

1. The information requested in this application is based upon the New Jersey Workers' Compensation Managed Care Organizations Rules (N.J.A.C.11:6-2) . Copies of this regulation can be obtained from the Department of Banking and Insurance at (609)984-3602. Copies of the application can be obtained at (609) 292-5436.

2. Complete the application cover sheet and provide all narratives and documents as described in the ensuing sections. Number each narrative and document according to the item number to which it responds, (e.g., III. Health Care Services #5- Quality Assurance). Number each page in the upper right hand corner. Tabs should be inserted indicating each of the six major sections of the application. Number all pages consecutively. Please submit the information in a three-ring hardcover binder and identify the submission on the front and spine of the binder.

3. A check or money order for $1,500 payable to the New Jersey Department of Health and Senior Services is to accompany the application.

4. If the WCMCO is not domiciled in New Jersey, the application must include a power of attorney duly appointing the Commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of such applicant in and for this State upon whom all lawful process in any legal action or proceeding against the WCMCO on a cause of action, arising in this State, may be served.

5. a. Two copies of the application must be submitted to:

New Jersey Department of Banking and Insurance
Life and Health Division
Managed Care Bureau
P. O. Box 325
20 West State Street
Trenton, NJ 08625-0325

b. Two copies of the application must be submitted to:

New Jersey Department of Health and Senior Services
Office of Managed Care
John Fitch Plaza, 6th Floor
P. O. Box 360
Trenton, NJ 08625-0360

WORKERS' COMPENSATION

MANAGED CARE ORGANIZATION (WCMCO)

APPLICATION FOR A CERTIFICATE OF AUTHORITY

COVER SHEET

1. Name of WCMCO

2. Affiliated Company(s)

3. Address

4. City 5.County 6. State 7. Zip Code

8. Telephone Number 9. Chief Executive Officer

10. Proposed counties of operations

11. Anticipated date of operation in New Jersey

12. WCMCO Fiscal Year (Reporting must be on a calendar year basis).

I certify that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

13. Name and Title 14. Signature 15. Date

16. WCMCO's Communication Liaison

I. **General**- Description and history of the WCMCO. Also include a detailed description of the WCMCO's experience with management of health care costs associated with Workers' Compensation and other health claims.

II. **Organizational/Legal**- The following documentation must be submitted:

1. Articles of Incorporation
2. By-Laws
3. List of owners (and investors)
4. Address of the WCMCO's place of business
5. List of Board members (names, addresses and occupations)
6. Names, titles and biographical affidavits of senior management personnel
   a. Medical Director Certification and biographical affidavit
7. Organizational charts (include all subsidiaries and affiliates)
8. A list of all in-force insurance.
9. Description of the grievance system.
10. Copies of executed contracts between the WCMCO and the insurer (if applicable) or sample contract.

III. **Health Care Services**

1. Summary description of the health care delivery systems and how accessibility, quality and utilization controls will be assured. Include the physician profile analysis. Indicate the method by which your network will be expanded or modified based on location of new customers' work sites.

2. Copies of executed provider contracts representing all services. There must be executed physician contracts sufficient in number and geographical distribution so as to assure accessibility for that number of enrollees projected for the end of the first year of operations. The WCMCO shall maintain an adequate number of Care Coordinator Physicians to provide the level and quality of medical treatment and services required under the Workers' Compensation. In lieu of executed contracts for specialists, secondary, tertiary hospital and the other services, there must be a detailed description of how all services will be arranged for and coordinated with Care Coordinator Physicians including a detailed listing of all hospital admitting privileges. When an WCMCO's service area comprises more than one county, there must be executed contracts for at least the Care Coordinator Physicians in each county and in lieu of executed contracts for the other services there must be a detailed explanation of how the WCMCO proposes to arrange for coordinate those services within each county, (also complete Table 2, 3 and 4).

   Copies of executed provider contracts means specimen copies of contractual

agreement(s) or other documents between the WCMCO and each provider/health care provider representative, and executed copies of signature, page(s) of contract, agreement or other documents.

3. Map detailing location of care coordinator physicians, frequently used specialists and in-patient care sites.

4. Map indicating location of potential customers' work sites.

5. Quality Assurance Program- Submit a detailed explanation of how the WCMCO will monitor and control quality of care for all its members including complaint resolution, physician peer review, a standardized medical record keeping system, UR programs, and case management programs.

6. Utilization Controls- Submit a detailed explanation of how the WCMCO will monitor utilization as well as develop controls specifically for under-treatment and/or over-utilization, as may occur with:

   a. Physician services
   b. Hospital services
   c. Lab services
   d. Therapeutic services
   e. X-ray services
   f. Out-of-area services

   The WCMCO shall also provide a description of its fraud detection plan, including measures for detecting and reporting possible fraud on the part of injured workers, employers, medical providers and others.

7. Emergency Care- Submit a detailed description of how emergency medical services will be available 24 hours a day, seven days a week.

8. Medical Records and Source Documents- Submit specimen copies of:

   a. medical record forms
   b. referral forms
   c. encounter forms
   d. other forms used by WCMCO

9. A list of the names, addresses and specialties of the individual providers that will provide services under the managed care plan. These lists should be arranged by county.

10. A list of the hospitals, rehabilitation centers, clinics and other facilities that will provide medical services.

11. A description of the WCMCO treatment standards and protocols that will govern the medical treatment rendered by all medical service providers, including care coordinator physicians. As a minimum, these standards must ensure that:

    a. The patient receives emergency treatment as soon as practicable, preferably by a participating physician.

    b. The patient receives initial treatment by a participating physician within 72 hours of notification (depending on the nature of the injury/illness).

    c. The patient receives initial treatment by a participating physician within five(5) working days or as soon as possible following treatment by a physician outside of the WCMCO network.

    d. The patient receives screening and treatment if necessary by an WCMCO physician in cases requiring in-patient hospitalization.

    e. The patient be directed to a medical service provider within a reasonable distance from the worker's place of employment.

    f. The patient receives treatment by a non-WCMCO provider at the direction of the care coordinator physician when the worker resides outside the WCMCO's geographical service area.

    g. The patient receives specialized medical services that the WCMCO is not otherwise able to provide. The application must include a description of the places and protocol of providing such specialized medical care.

12. A description of the program under the direction of a case manager involving cooperative efforts by the workers, the employer, the insurer and the WC-MCO to promote early return to work for injured workers.

13. Evidence of or the WCMCO's certification of malpractice insurance for each provider. Note: Should be a separate entry immediately after the provider contract section.

IV. Marketing

1. Description of initial geographic service area demographics (over all population figure, age/sex mix, target industries, socio/economic factors, etc.) which will affect enrollment.

2. Map of service area (new & existing, if expansion application)

3. Description of marketing strategy (including projected premium savings).

4. Marketing literature, including handbooks, and employer contracts. If final printed copies are not available, final draft or markup copies will be acceptable. Also include the outline of operation of the WCMCO provided to employers.

5. Enrollment Projections:

   Quarterly up to the first year following the year in which the Plan proposes to break-even, but no less than three years. These projections must be accompanied by realistic, specific assumptions.

6. A description of the method whereby the WCMCO will provide insurers with information to inform employees of all medical service providers within the plan and method whereby workers may be directed to those providers.

7. The outline of the operation of the WCMCO to be provided to employers explaining their rights and responsibilities.

V. Financial

1. Satisfactory evidence of the WCMCO's ability to maintain financial viability necessary to deliver of services.

a. Most recently audited financial report, or its capitalization and projections if a new WCMCO.

b. Unaudited financials up to the most recent period (month), income and expense statements, balance sheet, cash flow statement, changes in financial position (if an existing WCMCO).

c. Financial projections: Balance sheet, income cash flow statement and working capital requirements- quarterly up to first year following calendar year in which WCMCO is projected to break-even. (For expansion applications this must be broken down into "without expansion" and "with expansion" pro forma's.

d. Description of assumptions used in pro forma budget- these assumptions must explain every line item specifically and reasonably.

e. Justification or documentation underlying each assumption--each assumption must be accompanied by an adequate justification.

2. Describe the WCMCO's billing, provider reimbursement and collection procedures.

3. Describe the WCMCO's Financial Management Information System.

4. Explain other financial control systems: check signing procedures, petty cash controls, bonding policies, etc.

VI. Fee Structure

1. Provide the estimated savings in overall medical costs expected from the use of the WCMCO and the methodology used in arriving at such estimate.

2. Provide actual fee structure.

VII. Other

1. Any other materials specifically requested by the Department of Banking and Insurance or the Department of Health and Senior Services in connection with the application.

STATEMENT OF CHANGES IN FINANCIAL POSITION

OPERATIONS:

(1) Net Income.....

Noncash Revenues, Expenses, Gains and Losses Included in Income:

(2)
(3)
(4)
(5)
(6)
(7)
(8)
(9)
(10)
(11)
(12)
(13).....____

Cash Flow from Operations.....$

Investing:

(14).....$
(15).....
(16).....
(17).....

Cash Flow Investing.....$

Financing:

(18).....$
(19).....
(20)
(21)
(22)
(23)
(24)
(25)
(26).....____

Cash Flow from Financing.....

Net Change in Cash..... $_____

_____

_____

DEPARTMENT OF BANKING AND INSURANCE
LIFE AND HEALTH DIVISION
MANAGED CARE BUREAU

BIOGRAPHICAL AFFIDAVIT

Full name and Address of Entity (Do not use group name).
_____
_____
_____

In connection with the above-named Arrangement, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE", SO STATE. DO NOT LEAVE ANY QUESTIONS UNANSWERED.

1. Affiant's Full Name. _____
_____

2. a. Have you ever had your name changed? _____ If yes, state the reason for the change. _____

b. Other names used at any time. _____

_____

3. Date and Place of Birth. _____
_____

4. Affiant's Business Address. _____
_____

Business Telephone Number. _____

5. List your residence for the last ten (10) years starting with your current address, stating:

Date Address City/State

_____
_____
_____
_____

6. Education: Dates, Names, Locations and Degrees

College _____
_____
Graduate Studies _____
_____
Others _____

_____

7. List memberships in Professional Societies/Association.

_____
_____
_____

8. Present or Proposed Position with the Applicant Entity.

_____
_____

9. List complete employment record (up to and including present jobs, positions, directorates, or officership) for the past twenty- (20) years, stating:

DATES EMPLOYER AND ADDRESS TITLE

_____
_____
_____
_____

10. Present employer may be contacted. Yes _____ No _____
Former employers may be contacted. Yes _____ No _____

11. a. Have you ever been in a position that required a fidelity bond? _____
If any claims were made on the bond, state details. _____
_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked? _____
_____

12. List any professional, occupational, and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date license issued, issuer of license, date terminated, reasons for termination). _____
_____

13. During the last ten- (10) years, have you ever been refused a professional, occupational, or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? _____
_____

If yes, state details. _____
_____
_____

14. List any insurers, prepaid dental plans, health care corporations or health maintenance organizations in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power).
_____
_____

If any of the stock is pledged or hypothecated in any way, state details. _____
_____
_____

15. Will you or members of your immediate family subscribe to own, beneficially or of record, shares of stock of the application entity or its affiliates? _____
_____

If any of the shares or stock are pledged or hypothecated in any way, state details.
_____
_____

16. Have you ever been adjudged bankrupt? _____

If so, give details. _____
_____

17. Have you ever been convicted, had a sentence imposed or suspended, had a pronouncement of a sentence suspended, been pardoned for conviction of or pleaded guilty or no contest to any criminal information, indictment or complaint, other than minor traffic violations? _____

If yes, state details. _____
_____
_____

18. Have you ever been an officer, director, trustee, investment committee member, key employee, or controlling stockholder of any entity which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation, conservatorship, or bankruptcy? _____

If yes, state details. _____
_____
_____

19. Has the certificate of authority or license to do business of any insurer, prepaid dental plan, health care corporation, or health maintenance organization of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position? _____

If yes, state details. _____
_____
_____

Dated and signed this _____day of _____, _____ at _____. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____
(Signature of Affiant)

State of _____ County of _____

Personally appeared before me the above named _____ personally known to me, who being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____day of _____, _____.

(SEAL) **_____**
(Notary Public)

My Commission Expires_____

TABLE 1: INSURANCE COVERAGES	
COVERAGE TYPE	**BRIEF DESCRIPTIONS OF COVERAGE INCLUDING CARRIER DEDUCTIBLES, COINSURANCE PREMIUMS POLICIES MINIMUM AND MAXIMUM BENEFITS ARE IN EFFECT**
GENERAL LIABILITY	
CASUALTY	
FIRE	
THEFT	
FIDELITY BONDS	
OTHER_____	

TABLE 2: AMBULATORY SITES

Services Provided at WCMCO Site

Name of WCMCO Center/Sites	Location	Hours of Operation											

TABLE 3: HOSPITALS

SERVICES TO BE PROVIDED

NAME TITLE, AGREE-MENT OR JCAH CERTIFI-CATION	*LOCATION*	*OUT-PATIENT*	*IN-PATIENT TITLE XIX*	*WRITTEN*

BALANCE SHEET

MEMBERS

	AS OF:	*AS OF:*	*AS OF:*	*AS OF:*
Existing Area				
Expansion				

CURRENT ASSETS

Cash Restricted				
Unrestricted				
Accounts Receivable				
Marketable Securities				
Prepaid Expenses				
Inventories				
Total Current Assets				

OTHER ASSETS

Land				
Building/Leaseholds				
Equipment				
Less Depreciation				
Other				
TOTAL OTHER ASSETS				
TOTAL ASSETS				

BALANCE SHEET

CURRENT LIABILITIES

	AS OF:	*AS OF:*	*AS OF:*	*AS OF:*
Accounts Payable				
Payroll/ Taxes				
Unearned Fees				
TOTAL CURRENT LIABILITIES				
Long Term Liabilities				
Other Long Term Payable				

TOTAL LONG TERM LIABILITIES			
TOTAL LIABILITIES			

STATEMENT OF REVENUE AND EXPENSES QUARTERLY

_____*AS OF:* *AS OF:* *AS OF:* *AS OF:*

Other			
TOTAL ADMINISTRATION			
TOTAL EXPENSES			
Surplus/Deficit			
Federal Income Tax			
Surplus/Deficit (Net of Tax)			

STATEMENT OF REVENUE AND EXPENSES
QUARTERLY

MEMBERS	*AS OF:*	*AS OF:*	*AS OF:*	*AS OF:*
Existing Area				
Expansion				
REVENUES				
Fees				
TOTAL SERVICE REVENUE				
OTHER REVENUES				
Investments				
TOTAL OTHER REVENUE				
TOTAL REVENUES				
ADMINISTRATION				
Compensation				
Marketing				
Depreciation & Amortization				
Interest				
Operations Maintenance				
Insurance				

BALANCE SHEET QUARTERLY

OWNERS EQUITY	*AS OF:*	*AS OF:*	*AS OF:*	*AS OF:*
(For Profit) Capital Stock				
Additional Paid in Capital				
Retained Earnings				
Appropriated Retained Earnings				

(Non-Profit) Donated Capital			
Other			
Cumulated Sur/Def Prior Years			
Sur/Def Current Year			
TOTAL OWNER'S EQUITY/NET WORTH			
TOTAL LIAB. & OWNER'S EQUITY			